

HOSPITAL-NURSING HOME RELATIONSHIPS

Selected References Annotated

Prepared by
ANNE STAGEMAN
ANNA MAE BANEY

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Division of Hospital and Medical Facilities
Program Evaluation and Reports Branch
Washington 25, D. C.

In some instances, copies of Public Health Service publications listed in this bibliography are still available from the originating source. Publications issued by other sources may be available for reference at local libraries or from the author or publisher.

Public Health Service Publication No. 930-G-2

June 1962

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. - Price 25 cents

FOREWORD

Interest in the development of close working relationships between hospitals and nursing homes has grown steadily in recent years. A substantial number of experiments or demonstrations of hospital-nursing home coordination have been undertaken throughout the country. Various arrangements have been utilized, ranging from informal agreements for transfer of patients to complete administrative integration. In some communities, nursing home facilities are being operated as units of general hospitals. Such relationships are encouraged by the provisions of the Hospital and Medical Facilities (Hill-Burton) Program, which gives special consideration to nursing home projects operated by hospitals.

Increasing numbers of reports are appearing in periodicals and other literature on the subject of hospital-nursing home relationships. This bibliography was prepared in response to requests for information about published material in this area. It has been compiled from readily available publications and therefore is not necessarily exhaustive.

Suggestions for the inclusion of additional studies or reports in any future editions will be most welcome.

Jack C. Haldeman

Jack C. Haldeman, M. D.
Assistant Surgeon General
Chief, Division of Hospital
and Medical Facilities

ACKNOWLEDGMENTS

The authors wish to thank Mr. Kenneth R. Nelson, Jr., formerly acting chief, Nursing Home and Related Facilities Section, Division of Chronic Diseases, for his cooperation and assistance in providing materials for this publication. Appreciation is also expressed to the various other individuals who reviewed the manuscript and made valuable contributions, especially Miss Virginia Vahey, Division of Community Health Services, and Mr. David Lit, Bureau of Old-Age and Survivors Insurance, Social Security Administration.

HOSPITAL-NURSING HOME RELATIONSHIPS

American Hospital Association, American Medical Association, American Nursing Home Association, Blue Cross Commission, U.S. Public Health Service. Proceedings of Workshop on Hospital-Nursing Home Relationships. Chicago, Illinois, American Hospital Association, February 23-25, 1960. 60 pp.

This workshop was conducted to consider methods of improving hospital-nursing home relationships. The participants explored the problems involved in developing such relationships effectively, suggested solutions, and studied the role which should be played by each of the organizations and agencies concerned with this area of patient care.

Reports are included of panel meetings devoted to discussions of
(1) achieving effective hospital-nursing home relations and
(2) community planning for the long-term patient.

Four discussion groups considered the major problems relating to the provision of care for the long-term patient. The recommendations of each group are reported, and a composite of the conclusions of the four groups is presented.

Another publication concerning this meeting, Recommendations of Workshop on Hospital-Nursing Home Relationships, is available from the Council on Medical Service of the American Medical Association.

1. Barnes, R. C. Hospital and Nursing Home Go Well Together. The Modern Hospital 94:103-106, May 1960.

The operation of a nursing home in connection with a general hospital, the Eliza Coffee Memorial Hospital in Florence, Alabama, is described. The nursing home is located more than a mile from the hospital. The physical separation of the facilities has been found to be preferable in many ways, the author states, especially in establishing eligibility for admission of borderline cases and in creating a homelike atmosphere in the nursing home.

The demand for nursing home beds has caused the expansion of the home and further expansion is now planned. However, the tentative conclusion is that the ideal nursing home should not exceed 45 to 50 beds. In planning a nursing home, the author suggests, at least

one-fourth of the rooms should be in a soundproofed section to house noisy patients. Additional information to aid in planning the building and equipment is presented.

The patients admitted to the home are those generally classified as convalescent, chronic, or as having diseases of degeneration. The charge, which is identical for all patients, primarily covers room and board only; special services are extra. The care of the ambulatory or semi-invalid patient appears to require about the same amount of time as the bedfast patient, if not more.

Nursing home personnel requirements per patient day are slightly over one-half those of the hospital. However, since many of these requirements can be met by less skilled persons, the average cost per patient day for salaries in the nursing home is considerably less than half that for the hospital.

The dietary department, the purchasing of supplies for the home, and the method of dispensing medicines and drugs are also discussed.

3. Bass, Irving. The Best Homes Work with Hospitals. The Modern Hospital 84:78, 148, 150, May 1955.

The author points out the circumstances which have led to changes in the development of homes for the aged and which have often led such homes to establish arrangements with neighboring general hospitals. Since, he believes, providing other than minimal hospital services in the homes is impractical, these arrangements offer the most efficient and economical solution for the care of residents with acute illnesses.

Generally, such arrangements assure the residents of the homes they will receive hospital care when it is necessary and will be returned to the home after being discharged from the hospital. Also, if a home is associated with a hospital, members of the hospital medical staff may be assigned to the home's clinic. This in turn provides the hospital staff with experience in the chronic disease field.

Another area in which hospital-nursing home relationships have produced good results is the provision by the hospital staff of consultation and supervision of X-ray, laboratory, and other services in the home.

4. Bristol, Leverett F. and Paderewski, Mitchell, Dean, and Associates. These Long-Term Care Units Meet a Growing Community Need in California. Hospitals 32:33-34, July 1, 1958.

Since a number of long-term patients had been occupying acute beds in the Coronado Hospital, Coronado, California, and because a survey revealed a need for beds for nonhospitalized long-term patients, a 28-bed chronic and convalescent unit was added to the general hospital.

A registered professional nurse, assisted by practical and licensed vocational nurses, is in charge of each shift. The number of nursing hours needed by patients was found to be greater than anticipated; the wing is far from a minimal care unit.

Perhaps the greatest advantage to the hospital has been the availability of the wing for transfer of convalescent cases from the acute section, thus avoiding overcrowding in that area. Also, the less institutionalized atmosphere of the new wing is believed to have speeded the recovery of convalescents. It is believed the more liberal visiting hours and patient policies possible in this unit are of benefit to the chronically ill.

5. Cauthen, Campbell C. and Jones, W. Boyd. Contractual Relationships Between Hospitals and Nursing Homes for the Provision of Technical and Consultative Assistance. Proceedings of National Nursing Home Institute. Washington, D. C., American Nursing Home Association, October 1960, pp. 67-72. Processed. (Price: \$1.00)

A nursing home administrator and a hospital administrator described the successful development of a demonstration project of an affiliation relationship on a non-contractual basis, of a city-owned general hospital, an endowed nonprofit chronic disease hospital, and a proprietary nursing home.

The administrators of these facilities believe this project will be an effective guide for contractual relationships between hospitals and nursing homes in the areas of technical and consultative assistance. The benefits gained by the systems of transferring and following cases and of consultations are enumerated.

6. Cherkasky, Martin, M. D. Patient Services in Chronic Diseases. Public Health Reports 73:978-981, November 1958.

The author discusses misconceptions relating to the care of the chronic disease patient, and considers the greatest misconception to be that care for the chronically ill is inexpensive. In describing medical care needs, facilities, personnel, and costs, he states, it must be specified whether reference is being made to the active, acute, first phase, or the second phase, with its lesser demands on facilities and personnel and consequent lower cost. Intensive hospital care of high quality for a patient in the active phase of chronic illness costs at least as much as that for a patient with an acute illness.

It is stated that the following facilities and services are needed in a community to care for the chronically ill:

- (1) A general hospital, in which patients are not classified as acute or chronic. In effect, hospitals should be intensive care units. However, if patients need less extensive and less intensive medical and nursing care than that which is provided in the modern general hospital, they should be transferred to other institutions.
- (2) A home care program.
- (3) A nursing home, preferably on the hospital grounds. Even if the home is not so located, it should be under the hospital's auspices for medical care and medical care supervision. In this facility the patients would receive nursing care and rehabilitation designed to return them to the community.
- (4) A custodial institution for those who no longer belong in a hospital but cannot be cared for at home. It would be desirable to have this home either on or near the hospital grounds. Its medical care program should be under the supervision of the general hospital.
- (5) An adequate outpatient department in the hospital.

7. Clark, Elizabeth. Hospitals Need Nursing Homes. Nursing Homes 6:7, October 1957.

The role of Kansas nursing homes in the mental health program is discussed. Patients are referred to nursing homes when the needs of the patients can be better met in a home than in a State mental hospital.

The author relates the process which is followed to effect such a transfer and suggests procedures for nursing home administrators to follow after the transfer is completed, in order to achieve the maximum benefit to the patient.

8. Commission on Chronic Illness. Chronic Illness in the United States (Volume II): Care of the Long-Term Patient. Cambridge, Massachusetts, Harvard University Press, 1956. 606 pp.

Among other subjects, this comprehensive study covers the coordination and integration of services and facilities which provide care to the chronically ill. Examples are cited whereby arrangements for coordination of hospitals and long-term care facilities have been achieved. On the basis of its studies, the Commission believes that development of nursing homes as elements of general hospitals is one of the best ways to raise the standards for nursing home care, and that "when outright affiliation is impossible, a close and active working relationship should be maintained."

9. Conner, James F., M.D.; Devitt, Frederick B., M.D.; and Switkes, Herman I., M.D. A Hospital Unit for the Care of the Patient with Long-Term Illness: The Intermediate Service. Journal of Chronic Diseases 2:162-177, August 1955.

To provide for the care of the long-term patient effectively and economically, the Veterans Administration Center, Kecoughtan, Virginia, established a special hospital unit. Because of its functional position between the general hospital services and the domiciliary section, it is referred to as the intermediate service unit, rather than a nursing home section, convalescent hospital, or chronic hospital.

A 100-bed hospital unit, converted from a domiciliary barracks, was opened in November 1953. Design principles important in planning a long-term care unit are discussed.

It was found that one full-time physician could adequately supervise the care of 100 patients in this unit. The usual ratio in the acute medical wards of the main hospital was 1 physician to 30 patients. There were 13.3 patients per professional nurse on the intermediate service, as compared with 5.3 patients per nurse on the other general medical and surgical services. No significant difference between the number of hospital aides per patient in the acute and intermediate services was reported.

The authors state that the other professional and subprofessional personnel needed "to provide total care to its full extent can be provided on a practical basis for a unit of this size only through an integral relationship with a completely staffed general hospital or medical center. In addition, the consultation services in most specialities must be readily available from the full time or consultant staff of the acute hospital."

The roles of the key staff members are discussed. In addition to professional requirements, there are personal qualities essential for effective service in this type of unit.

As evidence of the rehabilitation potential of long-term patients under a dynamic program, 46 percent of the patients discharged from the unit during a six-month period were placed in the domiciliary section or in their own homes and many wheel-chair patients became completely or partially ambulant.

10. Decker, E. Hampton. Long-Term Care Unit: 24 Successful Years. Hospital Topics 36:27-29, July 1958.

The 51-bed long-term care unit of the Springfield Hospital, Springfield, Massachusetts (a general hospital) consists almost entirely of four-bed rooms. For many years after its opening in 1934, admissions were limited to welfare recipients; since about 1954, patients who pay their own charges have been admitted.

A major difficulty in the operation of the long-term unit was the preference of physicians and nurses to serve on wards caring for the acutely ill. The article relates how the problems of providing medical and nursing care have been met.

While the number of patients who must remain in the acute wards longer than necessary is lessened by the availability of the long-term unit, there are not always vacancies for patient transfer, since the unit operates at virtually 100 percent occupancy.

In 1957 the average cost per day in the long-term unit for routine care was \$7.66; for all-inclusive care, \$7.94. This latter cost was 36 percent of the cost of all-inclusive care in the acute wards of the hospital. The differences in cost result from several factors: the slow turnover, the lesser patient need for ancillary services, the higher usage of auxiliary personnel, the smaller ratio of total personnel to patients, and the high occupancy rate in the long-term unit.

The author lists the benefits of the operation of this unit to the community, the patient, and the hospital.

11. Deems, William A. Nursing Home is at Hospital's Doorstep. The Modern Hospital 96:99-104, April 1961.

This article describes the operation of a nursing home as a branch of a general hospital, Fayette County Hospital in Vandalia, Illinois; the home is located on the hospital grounds. Nursing, dietary, housekeeping, and plant services of the home are extensions of hospital departments. Medical care in the home is provided by the hospital medical staff. Licensed and other practical nurses and nursing aides care for the patients under the supervision of professionally trained staff. The kitchen facilities of the hospital are used.

The 33-bed home has an occupancy rate of 95 percent. The average stay is 59.2 days. Current charges range from \$7.00 to \$8.50 per day, exclusive of the cost of drugs and other services.

A detailed table, comparing nursing home and general hospital costs by department or function, is presented. Although the nursing home beds constitute approximately one-fourth of the total bed complement of the hospital and home, the operating costs for the home were only 13 percent of the combined operating costs.

12. Georgia Department of Public Health, Division of Hospital Services. Nursing Homes Operated by Hospitals. Hospital Notes, Atlanta, Georgia, December 1958. Processed.

This article presents the findings of a study concerning the operation of nursing homes in conjunction with hospitals. The survey included 36 hospitals and nursing homes throughout the United States. In most instances the nursing homes and the hospitals were physically joined. Only two of the 36 were operated separately.

The survey reported limited data on nursing home operating costs, staffing, ages of the patients, and ability of the patients to pay for their care.

13. Harrington, Augusta. A Case Study of Sparks Manor: Designed for Elderly Residents. Hospitals 32:34-37, December 16, 1958.

Data are given regarding the construction costs and the operating expenses of the 50-bed geriatric unit of Sparks Memorial Hospital, Fort Smith, Arkansas. This unit has sections for ambulatory and semiambulatory residents, for bed patients who need considerable nursing care, and for the mentally confused who need constant supervision. The fourth section houses the central facilities.

The administrator and the directors of the dietary and housekeeping departments of the hospital are responsible for the corresponding executive duties of the nursing home. Nursing service in the home is provided by five professional nurses, one practical nurse, seven aides, and three orderlies. A registered professional nurse is on duty during each shift. The staff also includes a physical therapist and an occupational therapist.

The monthly rate paid by each resident is determined by the amount of care needed. Rates are subject to change, as the patient's condition changes. These rates are exclusive of fees for doctors and private duty nurses, physical therapy ordered by doctors, X-ray and laboratory tests, and drugs and medications.

14. Illinois Hospital Association Select Committee on Care of the Aging. A Guide for Hospital-Nursing Home Affiliation. Chicago, Illinois, Illinois Hospital Association, November 10, 1961. 6 pp. w/appendices. Processed.

This guide, published in the interest of promoting closer hospital-nursing home relationships in Illinois, is also applicable to other localities.

Among the principles and objectives outlined are:

1. A coordinated utilization plan of facilities best meets a community's health needs.
2. When a hospital and a nursing home are operated under different auspices and do not share the same site, an integrated plan, based upon voluntary affiliation of the two facilities, can improve the quality and economy of medical care in the community.

3. Minimal standards for affiliating nursing homes should include State licensure and listing by the American Hospital Association or qualifications equally satisfactory.
4. The provision of the best quality of care available in the community at more reasonable cost is the principal objective of affiliation between an acute general hospital and a skilled nursing home. The components assuring this "best quality of care" are listed.
5. Articles of affiliation should be in written form, endorsed by all parties to the agreement.

Also presented in outline form are the elements of affiliation. These are grouped into several sections, including the transfer of patients between affiliating institutions, the continuity of medical care, the continuity of nursing care, dietary care, and other related phases.

As an appendix to the publication, examples of hospital-nursing home affiliations are cited. These examples cover various types and degrees of affiliation.

15. Kaye, Norman L. Nurses' Home to Nursing Home. Hospitals 32:39-41, September 16, 1958.

A former nurses' residence of the Saratoga Hospital, Saratoga Springs, New York, was remodeled for use as a nursing home. The building is located approximately 25 yards from the hospital. The home is supervised by a registered professional nurse, who is directly responsible to the hospital administrator.

During 1957, patients were given an average of 4.4 hours of nursing care a day. This care, which is slightly less than the amount given in the hospital, was divided according to type of personnel administering the service as follows: 60 percent by aides, 24 percent by practical nurses, and 16 percent by registered professional nurses. The percentage of care given by nonprofessional personnel is much higher in the nursing home than in the hospital.

There are three categories of charges, established according to the amount of care each patient needs. Approximately 25 percent of the patient load is nonambulatory.

The total cost per patient day of \$10.74 includes an estimate of indirect expenses. It is approximately half the per diem cost of the related hospital. Data are presented on the direct operating expenses of the home, by department or function.

The author discusses the difficulties arising from establishing and operating a nursing home in a building designed for other purposes and lists the advantages of having a long-term unit on hospital grounds.

16. Knudsen, Helen L., M.D. Hospitals Should Coordinate All Services Related to the Care of Long-Term Patients. The Modern Hospital 94:80, March 1960.

The author notes the rapid growth of interest in planning and developing facilities for the long-term patient, particularly nursing homes. However, she states that "from a community or a statewide standpoint, there is a serious lack of planning for the integration and coordination of services which will provide for continuity of care consistent with the changing needs of the patient. . . . Too little attention is being paid to providing an adequate staff and achieving the proper affiliations among the various types of existing care facilities and services."

So that older persons may remain in their own homes as long as possible, the author recommends extension of community hospitals' outpatient and home care programs and the expansion of visiting nursing and public health nursing services.

She states that the most acute need in the nursing home field at present is the provision of intensive nursing care under good medical direction. Therefore, she believes, a considerable portion of nursing home beds must be planned in units or wings of community hospitals. She lists ten advantages of a combined hospital-nursing home operation, including, in addition to readily available medical direction, the more efficient utilization of nursing personnel, the availability of laboratory and other diagnostic services, and the joint utilization of rehabilitation facilities and personnel.

17. Littauer, David, M. D.; Steinberg, Franz U., M. D.; and Gee, David A. Organizing and Operating a Chronic Disease Unit in a General Hospital. Parts I and II. Hospitals 33:26-30, 49, February 1, 1959 and 33:58-59, 63-64, 66, 68, February 16, 1959.

The chronic disease service of the Jewish Hospital, St. Louis, Missouri consists of two nursing divisions with a total of 68 beds. The 40-bed unit is for patients who are bedridden or confined to minimal wheelchair activity; a 28-bed unit is for ambulatory and semiambulatory patients. About one-third of the patients are ambulatory.

Since most of the patients are admitted from the acute divisions of the hospital, the chronic disease unit provides a means of transferring patients who no longer need care in the acute services to a unit suited to their needs.

The medical staff, nursing personnel, and ancillary personnel necessary for the operation of the 68-bed unit are enumerated, and descriptive data concerning each category are given.

The division is headed by a medical director, who is assisted by two other physicians; each is a specialist in internal medicine. There is a complete range of consultants in other medical specialties.

The long-term patients require almost as much nursing time as acutely ill patients. The average number of nursing hours per patient per day in the chronic unit is 3.04; in the typical acute medical service, the average is 3.80. However, in the chronic unit 2.25 hours of the nursing service is administered by nonprofessional personnel, as compared to 1.35 hours in the acute unit.

Admission and discharge policies are discussed. In general, a patient is admitted only if his condition requires care in a hospital setting. In 1957 the average length of stay for all patients was 168.9 days. Excluding the several custodial and nursing home-type patients, the average length of stay for treatable chronically ill patients was 131.9 days.

The rehabilitation needs of the patients are met through physical, occupational, and recreational therapy. Each of these services is discussed.

The per diem cost of the chronic disease unit was \$13.52. Since in 1957 the average patient payment was \$6.34 per day, there was a deficit of \$7.18 per patient day. The yearly deficit was underwritten by charitable organizations. The patients' sources of payment are analyzed.

The following advantages of a chronic disease unit in a general hospital are listed:

Long-term patients have available to them the same medical, nursing, and technical staffs that serve patients in acute units.

The diagnostic and therapeutic services and equipment characteristic of the general hospital are also available.

There is a free interchange of patients between services.

In a hospital setting the care of a chronically ill patient must meet the same qualitative standards as for short-term care.

Costs are not high in relation to the quality and quantity of service provided to the long-term patient.

18. McFarland, J. Lincoln. From Hotel to Hospital for \$104,000. Hospitals 32:41-42, December 1, 1958.

The Harrisburg Polyclinic Hospital, Harrisburg, Pennsylvania, purchased and renovated a small hotel building for use as a 40-bed long-term care unit. It was estimated, on the basis of almost two years' operating experience, that the original investment would be returned in approximately six years.

Admissions to the unit are restricted to transfers from the main hospital; however, some patients have been admitted after only one-day stays in the hospital. The majority of the patients are over

65 years of age and are chronic, rehabilitation, and convalescent cases. All are under the care of their private physicians.

The charges range from \$8.50 per day for semiprivate accommodations to \$10.50 and \$12.50 per day for private rooms. Physical therapy and minor medications are provided, upon orders by a physician, without additional charge.

Nursing care in the unit requires 3 to 3.5 personnel hours per patient day. Nurses' aides provide a large proportion of these services.

19. McKeever, Mary F. and Flance, I. J., M. D. Hospital-Nursing Home Liaison -- An Evaluation of Four Years' Experience. Hospitals 34:40-41, 104, August 1, 1960.

In 1956 the home care program of the Jewish Hospital of St. Louis was expanded to include a group of patients who could be served effectively through this program after placement in a nursing home. These patients, who either had no home or could not have been cared for at home, required either constant nursing care, but not intensive medical treatment, or custodial care because of senility and disorientation.

The home care program assumed complete responsibility for providing the services the patients required. Because of the supervision of these patients by the home care physician at the hospital, it was found, certain standards of care could be insisted upon.

The authors state that "the key to an effective hospital-nursing home liaison seems to be having a physician officially with the hospital or a program sponsored by the hospital." It was found that the administrators of nursing homes and foster homes respond well to the direction of a home care professional team.

Other means of effecting liaison between the hospital and nursing homes are being explored. In instances where it would be desirable to place patients in nursing homes for a transitional period before returning them to their own homes, it is believed that consultative services by the hospital, on a fee basis, would be of great benefit. Members of the hospital's rehabilitation program would provide guidance at the request of the nursing home.

20. McKeown, Thomas, M. D. A Balanced Hospital Community. Hospitals 33:40-44, 107, August 16, 1959.

As a guide for future hospital planning, the author recommends that hospitals representing all facets of service be grouped on a single site, and that the medical and nursing services for such a center be provided by a common staff. The buildings should be of varied size, design, and permanence of structure and equipment.

The following problems which appear to be insoluble within the existing hospital framework are enumerated: (1) the inadequacy of care offered to the aged sick and the mentally ill, (2) the mixing of patients having different needs within the same building, and (3) the designing and siting of hospital buildings so that they will not soon be outdated. These and other problems, it is stated, are due to the separation of hospitals for the mentally and chronically ill from the general hospitals and the concept of the hospital as a single structure which provides the full range of services for selected classes of patients.

As a suitable basis for planning, it is suggested that patients might be classified into four groups, such as those requiring: (1) the full resources of a modern hospital; (2) limited hospital facilities because of physical illness; (3) limited hospital facilities because of mental illness; and (4) custodial care only. Thus, the hospital center would consist of four major units, built to meet the varying needs of the patients. Three of these buildings could be of relatively simple construction.

There are many advantages, the author believes, in having all hospital services, planned to bring together those who have common needs, on a single site, served by a common staff. Among these advantages are:

The standard of care would be raised by overcoming the difficulty of recruitment of physicians and nurses to mental and long-term hospitals. Placing these hospitals close to the general hospital would permit the same staff to serve all institutions.

Patients could be transferred from one unit to another, as their needs changed.

There would be no duplication of expensive facilities.

Some of the most difficult medical problems would be brought to the attention of research workers.

All patients would be accepted equally as a medical and nursing responsibility and interest.

1. Morris, Robert. Basic Factors in Planning for Coordination of Hospitals and Institutions for Long-term Care. New York, Council of Jewish Federations and Welfare Funds, Inc., October 1960. 45 pp. Processed.

This report presents the results of a study of the process of planning for a change in the existing pattern of service organizations in six communities. In each community a central planning body had attempted to bring about a new relationship between a general hospital and a long-term care facility. The study covered the period from the inception of the idea of planning for coordinated care until completion, either by success or failure of the project.

The history of each plan was analyzed to discover the factors accounting for the differences in achievement among the six communities. As an aid to effective planning, the author cites conclusions drawn from this analysis.

2. Morris, Robert. Coordination of Personal Health Services: A Study of Relationships between General Hospitals and Institutions for Long-term Care. New York, Council of Jewish Federations and Welfare Funds, Inc., May 1959. 44 pp. Processed.

Ten cases of either close cooperation or integration of services between hospitals and nursing home-type facilities were studied to determine the feasibility of such liaison. In each of the ten cases studied there was some pooling of staff, facilities, or services between the hospital and the home.

The author analyzed in which respects and to what degrees professional and administrative cooperation was achieved among the eight hospitals and ten homes. The study revealed that substantial integration of physicians' services can be attained. The sharing of clinical laboratory services is another area in which cooperative planning was effected.

In five instances, the hospital and home shared the services of a chief of physical medicine or rehabilitation, who supervised physical and occupational therapy programs in the home. There was little exchange between the physical and occupational therapy staffs of the

two types of facilities and limited transfer of patients for rehabilitation. One of the several reasons advanced for this is that the rehabilitation programs of each type of institution are geared to different goals -- short-term treatment in an acute hospital and prolonged treatment in a home.

In a few cases experiments in joint purchasing were unsuccessful. Most of the homes have preferred to purchase their own supplies. The author states that no clear advantage has been demonstrated for joint purchasing.

The analysis by the author of the relationship between the hospitals and the homes indicates that substantial benefits had been derived by the long-term facilities, but that direct benefits to cooperating hospitals were minimal. However, future benefits to the hospitals are anticipated.

23. Morris, Robert. Expansion of Cooperative Relationships between Hospitals and Nursing Homes. Public Health Reports 75:1110-1114, December 1960.

Nursing homes have become a major component of comprehensive medical care, the author points out, and now provide almost as many beds as general hospitals. He states that the development of nursing home care has not been much influenced by the health professions; however, the hospitals and nursing homes must be brought together as "partners in the same health-serving team" in order to achieve continuity in medical care, particularly for long-term patients.

The basic characteristics of the two types of organizations which make partnership difficult and the attitudes which have accentuated these differences are analyzed. Experience in several communities, however, suggests that these difficulties can be overcome.

The author discusses five types of cooperative efforts which have been tried successfully: (1) informal arrangements for transferring patients; (2) training exchanges; (3) joint planning for patient care; (4) joint appointment of specialized staff; and (5) administrative integration.

24. Morris, Robert and Slawson, Robert. Coordination of Medical Services between General Hospitals and Long-term Care under Jewish Auspices. Chronic Illness Newsletter 6:2-4, May 1955.

The authors state that the increasing coordination between general hospitals and long-term care facilities will be of significance in bringing about central planning and financing of services to the aged, the chronically ill, and convalescent patients.

They point out two factors leading to the growing integration of medical services: (1) the presently emerging role of the general hospital as the center of all medical services to the community; and (2) the increasing number of chronically ill residents in institutions and in homes for the aged.

Twenty-four Jewish general hospitals replied to an inquiry concerning arrangements between the hospital and long-term care facilities. Various ways in which coordination or integration had been effected by responding hospitals are described.

25. Nelson, Kenneth R., Jr. Program of Hospitals and Nursing Home Provides Better Care. Professional Nursing Home 3:16-17, 27-28, August 1961.

This article discusses a hospital-nursing home relationship, established in Anniston, Alabama by a 160-bed city-owned general hospital, a 30-bed nonprofit chronic disease hospital, and a 48-bed proprietary nursing home.

Under a plan developed with the aid of the Nursing Home and Related Facilities Section, Division of Chronic Diseases of the U.S. Public Health Service, specialists of the city hospital will be available on a consulting basis to the other two facilities to enable them to obtain the technical advice and services they need. The cost of these services will be paid by the facility which receives them.

In-service training programs, which were limited and costly, were being conducted at each of the facilities prior to the affiliation. Through the cooperation of the three institutions, a course for nurses' aides, orderlies, and similar employees was set up, to be inaugurated by the in-service training director of the hospital. In addition, principal staff members of the three institutions will take special courses at the hospital. Training courses were already being given by the hospital on a limited basis, but it is believed that, through the cooperation of the hospitals and the home, they may be expanded in scope and number.

Plans were being developed to allow students in the general hospital's licensed practical nursing training program to receive, if they wish, certain portions of their clinical training at the chronic disease hospital and the nursing home. This training is intended to aid the practical nurses in the care of geriatric patients.

A one-year contract provides for the formation of an advisory board and an executive committee to oversee the program.

The cooperating institutions feel that the system of consultation has resulted in improved dietary standards, better patient nutrition, and better protection of the patient should there be a fire or other disaster.

Certain procedures and records were standardized by the three institutions to facilitate patient transfers. Reproductions of the form developed for the purpose of effecting transfers and for requesting services, as well as that developed for requesting consultation, are included.

The system of patient referral has become a major consideration of the affiliation. The program of continuous medical care fostered by this system is expected to produce the following long-term benefits to the institutions: the availability of more hospital beds, reduction of hospital stay, and a more efficient utilization of hospital services. Patient benefits include: continuous medical care, more rapid recovery and physical restoration, and a greater opportunity to return to community life.

26. Nicholson, Edna E. Planning New Institutional Facilities for Long-term Care. New York, G. P. Putnam's Sons, 1956. 358 pp.

This report, which covers all aspects of planning for the care of the chronically ill, devotes a section to nursing homes, described as "all facilities for long-term care of people who require a home with personal attention and nursing care."

To provide good care for long-term patients, the author states, it is essential that the facility provide full diagnostic and treatment services within its own program or that it operate in close relationship, both administratively and geographically, with a general hospital. It is more efficient and economical to provide these services through relationship with a general hospital than to provide them in a facility where they are not used with sufficient frequency to justify duplicating the equipment and personnel of a general hospital.

It does not cost more to operate long-term care units in connection with general hospitals than it does to operate them independently, if good care is provided in the long-term units. Experience indicates that satisfactory long-term care costs approximately two-thirds as much as the cost of providing general hospital care.

Unless the combined general hospital and long-term care unit exceeds 500 beds, there is a substantial saving in the cost of operating a long-term care unit as part of a general hospital through the sharing of administrative personnel, the use of a common heating and maintenance unit, and the purchasing of supplies and equipment in larger quantities.

Moreover, the quality of care for chronically ill patients can be more readily improved under the auspices of a general hospital than in any other way. In addition, under such an arrangement a more efficient use can be made of specialized personnel and equipment.

Research into the causes of chronic illness and methods for its prevention and control will be furthered by having the long-term unit in a general hospital. The presence of the long-term patients in the hospital will create an awareness of their needs and their accessibility to the research activities of the general hospital will make it more feasible to include them in various projects.

The author states that, although the operation of long-term units in connection with general hospitals seems to be the best plan, good long-term care can be provided in independently operated facilities, if it is possible to transfer the patients to and from a good general hospital quickly, and if the patient can remain under the care of the same physician throughout his illness.

7. Roberts, Dean W., M.D. Hospital Unit for the Long-term Patient. The Modern Hospital 83:68, 150, 152, September 1954.

Since chronic illness is characterized not only by its length, but also by the changing needs in treatment and care, the author states, long-term patients require a broad range of services and coordination of these services. Therefore, in planning for the care of the chronically ill he suggests that it is necessary that the services needed be linked sufficiently close to make them readily available to the patient when needed. Opinions differ as to how this coordination should be achieved, whether by the provision of all services by a single institution or through a close administrative relationship of separate facilities.

At some point, most long-term patients require hospital level care. Whether this care is provided in a chronic disease hospital or a long-term unit of a general hospital, "intensive evaluation and definitive medical treatment" and "a rehabilitation service organized so that rehabilitation is started immediately upon admission" must be provided. In addition, physical surroundings must be planned for persons who must remain there for a long period, the schedule of charges must take into consideration the problem of payment for a program of care for an indefinite period, and there must be an effective discharge program. This discharge program would require that there be proper places for the patients no longer needing hospital care. To insure this, the unit would probably need an affiliation with nursing homes, with other convalescent facilities, and with home care programs.

28. Rodstein, Manuel, M. D. and Zeman, Frederic D., M. D. The Utilization of General Hospitals by the Population of a Modern Home for the Aged. American Journal of Public Health 50:1901-1904, December 1960.

This article discusses the relationship of a home for the aged and infirm with neighboring general hospitals. The policy of this home "is to function as an intermediate medical facility serving areas of medical need not otherwise met by existing facilities." It provides most of the care needed because of chronic illness of residents, but does not attempt "to care for conditions which demand special staff and equipment with which the general hospital is already provided." The home serves over 1,000 aged persons, whose physical condition ranges from fully ambulatory to completely disabled, in two main centers, two apartment residences, and as members of an extramural care group.

The home has an arrangement with a private ambulance service to effect transfers between the home and general hospitals. The decision to seek transfer to a general hospital is on advice of the home's attending staff and the transfer is arranged through conference of the home's chief resident physician and the hospital's admitting physician. Prior to the discharge of a patient from the hospital, the resident physician of that institution informs the resident physicians of the home regarding current status, medications, and recommendations for further care. Contacts are also made between the social workers of the two institutions.

The following advantages of the interrelationships of the home and the general hospital are cited: the necessity for the proximity of a home

to a general hospital is averted, the expenditure of funds for unnecessary hospital stays is reduced, and the maintenance of high standards of medical care in the home is aided.

Ioan, Raymond P. Community Hospital Adds a Long-term Unit.
Modern Hospital 90:55-58, February 1958.

The long-term nursing unit of the Princeton Hospital, Princeton, New Jersey, which provides care for 42 convalescent, geriatric, and chronically ill patients, is located in a remodeled home three blocks from the main hospital buildings.

Representatives of the hospital board establish the policies of the unit and the medical program is under the jurisdiction of a member of the hospital staff. The supervisor of the nursing staff of the nursing home is responsible to the nursing director of the hospital. The nursing staff includes five registered professional nurses, five practical nurses, three aides, and an orderly.

Patients' fees cover the services of the home physician, routine nursing care, rehabilitation and occupational therapy facilities, minor medication, meals, bed laundry, and the use of all facilities.

Olson, Jerry and Baney, Anna Mae. General Hospitals and Nursing Homes: Patterns and Relationships in Their Geographic Distribution. Public Health Monograph No. 44. Washington, D. C., U.S. Government Printing Office, April 1956. 56 pp. (Price: 40¢.) Also, General Hospitals and Nursing Home Beds in Urban and Rural Areas, Public Health Reports 71:985-992, October 1956.

These two reports analyze the national availability of general hospital and skilled nursing home beds in terms of (1) general hospital service areas which correspond to trading areas for hospital services and (2) counties classified according to their urban or rural character. The analysis was "designed to explore the interrelationship in availability of the two types of facilities and to define relationships between their comparative availability and socioeconomic characteristics of areas." The factors examined included per capita income, proportion of aged population and availability of medical personnel.

The study stresses the importance of relating the planning of nursing homes to the availability of general hospitals, because of the need to coordinate nursing home and general hospital services.

31. Sudduth, James N. and Whitten, Lawrence. These Long-term Care Units Meet a Growing Community Need in Alabama. Hospitals 32:32, July 1, 1958.

The 30-bed nursing home built in conjunction with Chilton County Hospital, Clanton, Alabama, is connected with the hospital by a long corridor. This type of construction, the authors state, offers many advantages. The facilities of the hospital are thus immediately accessible to the residents of the home, if necessary. It is convenient for the medical staff. All food for the home is prepared in the hospital kitchen and all sterilization is done in the hospital. The home is staffed by nursing aides and orderlies. However, a registered professional nurse from the hospital makes routine rounds.

32. Ten Architects Offer 11 Plans for Long-Term Facilities. The Modern Hospital 94:79, 82-99, March 1960.

Plans, construction costs, and brief descriptions of 11 facilities for the care of the chronically ill and the aged are presented. Several of these facilities are nursing homes operated in connection with general hospitals.

33. The Hopedale Complex. Professional Nursing Home 3:12-14, 29, July 1961.

The Hopedale Complex was built on a five and one-half acre site in Hopedale, Illinois, a town of 500 population. The complex includes a 20-bed general hospital, a 40-bed nursing home, a residence for 44 people over 50 years of age, and a nurses' residence.

The hospital, the first unit of this complex to be constructed, was completed in 1955. After experience showed that much of the patient complement was composed of those who were chronically ill, a nursing home was added. In this home, which provides a "more easy going, pleasant atmosphere" for such patients, the charges are 65 percent less than those of the hospital. It is reported that the home not only provided a suitable place for the chronically ill, but the hospital more than tripled its net profit, since it was able to more fully use all of its services.

After it was found that many nursing home patients were there only because they were aged, alone, and had no place to go, a residence for the elderly was constructed. This facility contains apartments and single and double rooms. Charges to the residents will be about 50 percent less than the charges in the nursing home.

The complex demonstrates, it is stated, that a community does not have to be large to have facilities for the care of the chronically ill and aging. Such facilities are an economic advantage to the community, since older citizens will remain if their needs can be met.

34. U. S. Department of Health, Education, and Welfare, Public Health Service. Report, National Conference on Nursing Homes and Homes for the Aged. Washington, D. C., February 25-28, 1958. 85 pp.

The participants at this conference, called by the Public Health Service, reviewed the problems and the future role of nursing homes and homes for the aged in caring for the chronically ill and aged. Sectional working groups were assigned the discussion of various aspects of nursing home care and requested to develop specific recommendations. Two of these sectional groups presented recommendations regarding nursing home-hospital relationships. While varying points of view were expressed, the promotion of planned cooperative arrangements between hospitals and homes for the aged and nursing homes and the encouragement of the establishment of nursing homes under the jurisdiction of hospitals were advocated.

35. Walker, Robert. Minimal Care Unit Lowers Patients' Bills, Frees Acute Care Beds. Hospitals 35:60-64, August 16, 1961.

As a result of a patient survey showing that on almost any day at least one patient in five did not require full professional hospital care, the North Carolina Baptist Hospitals, Winston-Salem, North Carolina, established an 80-bed minimal care unit through the conversion of an adjoining building previously used as a student nurses' residence.

The cost per bed for this unit, known as the Progressive Care Center, was \$10,000. Each of the 80 rooms has a private bath, telephone, and remote-control television set.

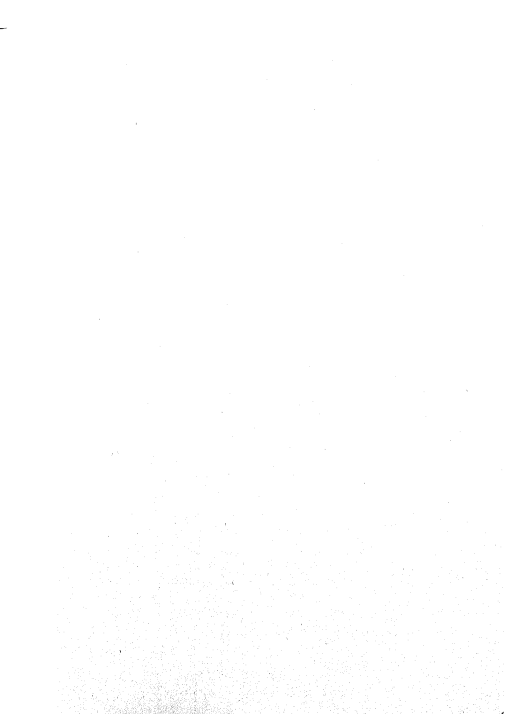
To be admitted to the center patients must be transferred from the Baptist Hospital for convalescence or admitted for diagnostic studies or a therapeutic regimen not requiring intravenous drugs. They must be able to walk to meals.

Per diem room charges in the Center range from \$7.00 to \$12.00, as compared with per diem charges at the hospital of \$13.50 for the least expensive ward bed, of \$18.00 and \$18.50 for semiprivate rooms, and of \$26.00 for the most expensive private room.

The cost of operating the Center is \$3.80 per patient day. The most important difference between its cost of operation and that of the hospital is the savings in payroll. The hospital has 2.71 employees for each patient; in the Center there are three patients to one employee. The nursing station is staffed on a 24-hour basis by a professional nurse, a licensed practical nurse, and an aide.

The Nursing Home and Related Facilities Section, Division of Chronic Diseases, U.S. Public Health Service, Washington 25, D. C., recently prepared the film, Working Together. This 25-minute, color, sound motion picture summarizes the experiences of 18 hospitals and nursing homes in 8 communities throughout the United States in their development of cooperative relationships.

This film is available on loan from the Communicable Disease Center, Atlanta 22, Georgia, and for purchase from the United World Films, Inc., 1445 Park Avenue, New York 29, N. Y.



ected related publications from the Hospital and Medical Facilities Series
er the Hill-Burton Program are listed below by category:

Regulations

- Public Health Service Regulations - Part 53: Pertaining to Hospital Survey and Construction (Hill-Burton) Legislation. PHS Publication No. 930-A-1. Revised 1962.
- General Standards of Construction and Equipment: Long-Term Care Facilities. PHS Publication No. 930-A-3. Revised 1962.

Community Planning

- Areawide Planning for Hospitals and Related Health Facilities: Report of the Joint Committee of the American Hospital Association and Public Health Service. PHS Publication No. 855. July 1961.
- Planning of Facilities for Mental Health Services. PHS Publication No. 808. January 1961.

Organization - Administration

- A Suggested System of Uniform Expense Accounting for Nursing Homes and Related Facilities. PHS Publication No. 835. 1961.

Design - Equipment

- Planning and Equipping the Nursing Home. March 1956.

Reports - Analyses

- Nursing Homes: Their Patients and Their Care. (Public Health Monograph No. 46.) PHS Publication No. 503. 1957.
- Personnel Time in Nursing Homes of Washington State. January 1958.

Bibliography

- Administration and Operation of Nursing Homes and Related Facilities. April 1960.
- Costs of Operating Nursing Homes and Related Facilities. PHS Publication No. 754. May 1960.
- Selected Bibliography: Planning for Long-Term Patients. August 1961.

te: An annotated bibliography, "Hill-Burton Publications," Public Health Service Publication No. 930-G-3, is available upon request. For single copies write to: Division of Hospital and Medical Facilities, Public Health Service, U.S. Department of Health, Education, and Welfare, Washington 25, D. C.